WORKSHOP ON IMPROVING AWARENESS ON KEY POPULATION HEALTH NEEDS AND HEPATITIS C (HCV) AMONG HEALTH CARE WORKERS AND COMMUNITIES

DOCUMENTATION REPORT

3rd December 2018

Double Tree Hilton Hotel

Johor Bharu

Table of Contents

BACKGROUND

Under the Coalition Plus funding 2018 received by MAC, the focus has been on interventions for tackling Hepatitis C which is a neglected disease in Malaysia. To begin with, efforts were focused on raising public awareness with the creation of a Hepatitis C specific website myxhepc.com and related twitter handle and facebook page to especially engage the younger generation via an online social media based video/poster/meme contest in March 2018 with #MYXHEPC hashtag. MAC has also developed a community friendly toolkit in simplified local Malay language to raise awareness among key populations and for this purpose a one day consultation was held on 27th April 2018 followed by a one day content finalisation workshop on 4th October 2018, the toolkit will be ready by December 2018. Besides the toolkit aimed at outreach workers to enable them to better understand and explain the disease to clients an abbreviated pocket booklet was also produced for clients to emphasise the importance of testing which outreach workers can distribute far and wide. The toolkit content is not only to be printed as a training material but also uploaded online as a resource for not only outreach workers but also to benefit anyone who is at risk and needs to have a more detailed yet basic understanding of Hep C in simple local Malay language. Promotion of this community friendly toolkit resource will be done continuously via e-posters on social media which will also help raise public awareness indirectly.

To better coordinate and build up on efforts by MOH and other NGOs like DNDi, TWN and MTAAG+, MAC organised a 2 day workshop: "Enhancing Surveillance: Increasing Awareness and Eliminating HCV". held on 22nd and 23rd November in KL which brought together representatives from MOH, government healthcare providers and NGO representatives to update each other on mutual efforts to overcome the Hepatitis C epidemic in Malaysia with a view to enhance more effective future collaboration.

As a further effort to raise awareness of Hepatitis C among healthcare providers and related key populations, this 1 day workshop: "Improving Awareness on key population health needs and Hepatitis C (HCV) among health care workers and communities" was organised in Johor Bharu for southern region Healthcare Providers and Johor Bharu based NGO workers with the following objectives:

- To provide the platform for community and healthcare workers to discuss on health needs of Key Populations
- To introduce Hep C epidemiology and treatment available in government hospitals/clinics

Welcome Speech

Given by Han Yang who thanked everyone for being there and introduced himself before getting the participants to introduce themselves accordingly. The participants were asked to explain their involvement with Hepatitis C. From the introductions many expressed the fact that hepatitis C was a relatively new field to them however at the same time there was an obvious sense of urgency with many noting that this workshop was indeed timely and calling for more efforts to address the rising epidemic of Hepatitis C.

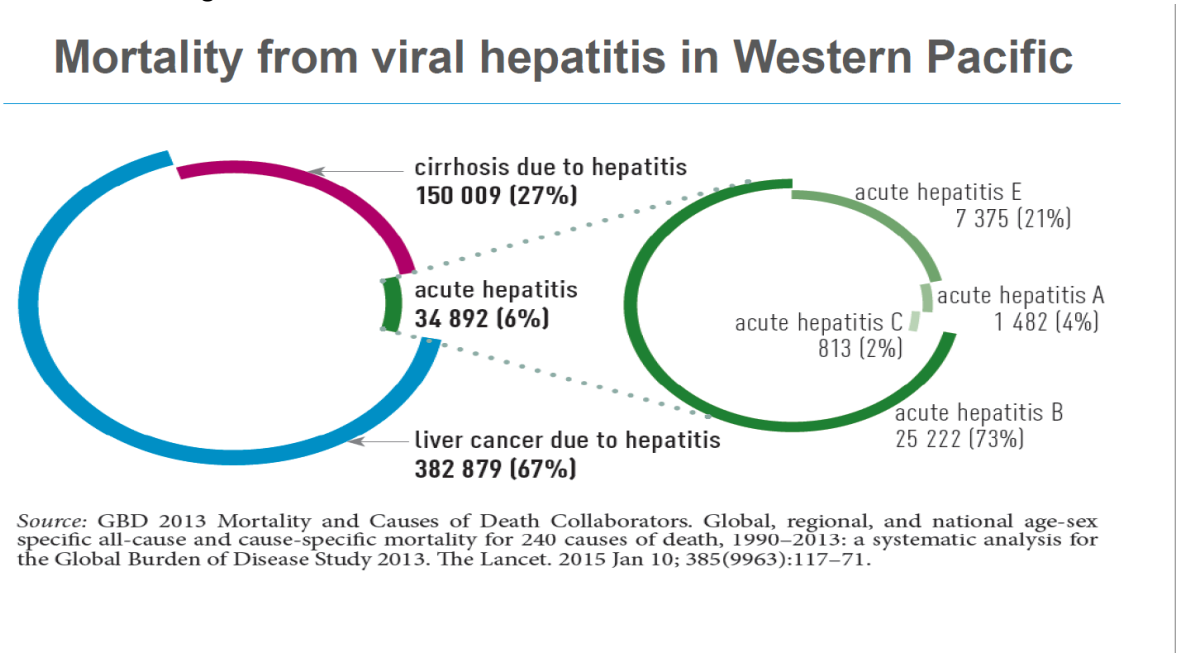
Presentation 1: HIV and Key Populations: Who are they in the community? & Initiatives and programme available addressing needs of Key Populations

By Chung Han Yang, Resource Person

Han Yang began by highlighting the multi-disciplinary approach that we have been using for HIV intervention involving various parties including MOH, all levels of health care providers, NGOs,

researchers and other technical partners, funders etc all working together. He then explained the objectives of todays workshop (ref background) and said that we can use what we know from HIV and MMT intervention to fashion a similar approach to Hep C intervention. He briefly went through the agenda for the day (refer to Appendix 1). Han Yang proceeded to give an overview of the HIV epidemiology in Malaysia with a focus on PWID and MMT before switching the focus on Hep C.

The estimates of people with Hep C in Malaysia is 453,000 based on a study in 2015 by Mc Donald A, and so far we have only diagnosed a fraction of that estimate. The prevalence among PWID based on the data so far is estimated to be at least 50%. He then mentioned the targets set by WHO for Hep C both globally and regionally and highlighted the mortality from Hep C in the Western Pacific in 2016 as shown in the diagram below:



Source: GBD 2013 Mortality and Causes of Death Collaborators. Global, regional, and national age-sex specific all-cause and cause-specific mortality for 240 causes of death, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet. 2015 Jan 10; 385(9963):117–71.

Given that Hepatitis C is affecting PWID as a key population we should look at how the MMT and NSEP programs were effective in as HIV harm reduction interventions. Basically it all boils down to a client centered holistic multiagency and multidisciplinary approach. Unfortunately there are still challenges faced especially in terms of lack of enabling environment as PWID still face stigma and discrimination, Malaysia as a nation is still a long way away from decriminalising drug use despite some encouraging movement towards legalising medical marijuana. Ultimately it is hoped that instead of treating drug users as criminals we should treat them as patients to be treated for addiction to or abuse of drugs. The barriers faced by PWID to access healthcare was then discussed in detail which included the following factors

- Cost/affordability of medication
    - Many face difficulty finding steady jobs
- Crimilisation
    - Forced rehab / imprisonment
- Strict Treatment protocols that make it challenging
    - eg need for fixed home address and to be “registered” as a drug user to get harm reduction services
- Stigma and discrimination from society in general
    - Also in healthcare settings

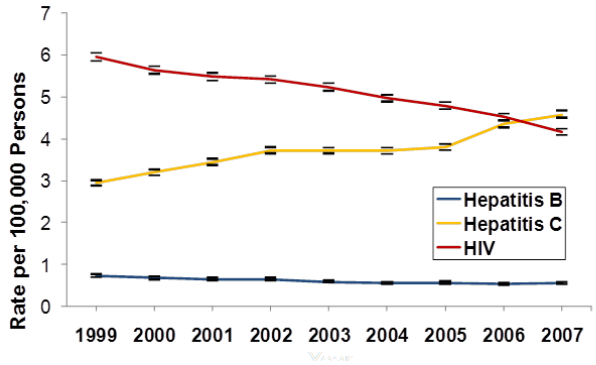
The presentation ended with a brief time check was done by looking through the agenda again.

Presentation 2: Treatment & Challenges Community Perspective

By En. Edward Low, Director, Positive Malaysian Treatment Access & Advocacy Group (MTAAG+)

Edward began by introducing himself as A PLHIV advocate and the work that MTAAG+ does which includes research on medicines (HIV, Hep C, Cancer drugs), capacity building workshops for KP and HCP as well as campaigns on access to medicine such as how they ised to object to TPPA and now againt CPTPP. Before the proceeded to his presentation he noted that basically a lot more needs to be done to improve Hep C meds access and how MTAAG has a pool of clients and even 2 staff who are PLHCV on waiting list for meds.

He noted that hep c is a global pandemic with an estimated 30m people needing treatment worldwide. The mortality from Hep C has been higher than HIV since 2007 as per diagram below:



In Malaysia it is estimated that at least 380,000 people are infected by Hep C.

Moving on to what was community based testing, he explained the different ways it could be done

1) Mobile clinic / Outreach site based testing approaches.
2) Door-to-door/home-base testing.
3) National testing campaigns. (Word Hepatitis Day, 28th July)
4) Mass media and social media.
5)Workplace testing.
6)Testing in schools, colleges or educational establishments.
7) Testing in prison & other correctional system settings.

He then explained WHO's 5C's for Hep C testing which they adhered to:

1) Consent,
2) Confidentiality,
3) Counselling,
4) Correct test results and
5) Connection (linkage to prevention, treatment and care services)

The importance of testing being voluntary was emphasised as mandatory, compulsory or coercive hepatitis testing is never appropriate. From their experience in promoting voluntary testing by starting with HCV awareness, the response to do testing has been good esp now that there is a cure available for Hep C. MTAAG did a pilot project for 3 prisons in 2018 for high risk KP who have never tested in collaboration with Suhakam. Screening was done for around 180 inmates and they detected Hep C on average in 40% of the cases who were totally unaware of their infection.

The window period of different types of tests is crucial to determine how often high risk KP should test if they are not detected to be positive for Hep C

Type of Hep C test	**Window period**
Antibody	3 months
Antigen	1 month
RNA	0-1 month

The rapid test kit that MTAAG+ used is SD Bioline which cost Rm7 per kit and can be done with finger prick.

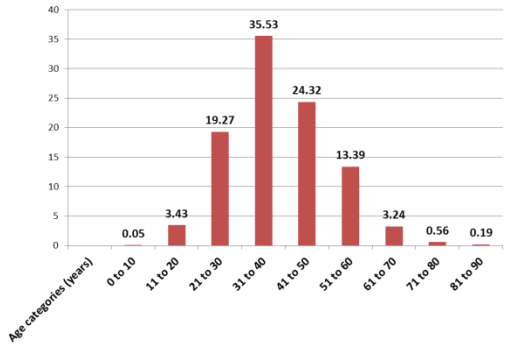
Edward then spoke about the type of DAAs available in Malaysia and how the supply is still way too low which means the need is there for further advocacy. He ended by emphsising some takeaway points which he felt were important:

- We should Treat everyone who needs it regardless if they've been re-infected,
- increase funding for peer support workers/educators at HRS which could ensure better training
- information-sharing on prevention and safe drug consumption practices to avoid reinfections.
- We need strong commitment by government to sustainably finance elimination.
- government should not pit patients against each other:
- Putting resources into HCV treatment among PWID is cost-effective and cost-savings;
- it is not taking away funding for other disease areas or publicly funded programs.

Presentation 3 : HCV Treatment and Challenges Clinicians Perspective

By Dr Tan Soek Siam, Consultant Hepatologist Selayang Hospital
& President of Malaysian Society of Gastroenterology and Hepatology

Dr Tan introduced herself as the Consultant Hepatologist at Selayang Hospital & also president of Malaysian Society of Gastroenterology and Hepatology before proceeding to give some background on Hep C in Malaysia. She spoke anout global targets for Hep C elimination and stressed that Malaysia needs immediate substantial scale up in diagnosis and treatment of Hep C to achieve elimination targets. Treatment scale-up will be instrumental in decreasing the complications from Hep C such as liver cancer for example. She then touched in prevalence and how a 2012 study detected prevalence as high as 80% among a sample of high risk KP on MMT. Based on the age distribution of Hep C cases notified in 2014 as shown below, it can be said that HCV infection starts at a young age in Malaysia.

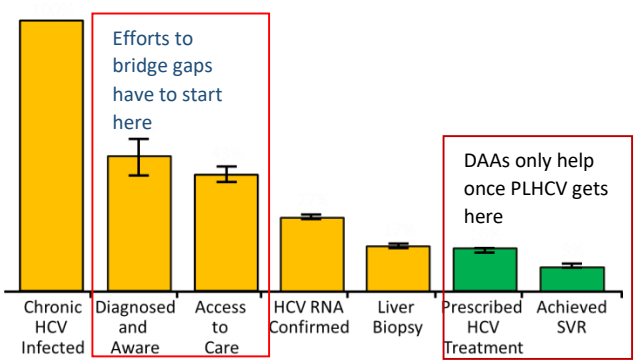


HCV treatments in Malaysia has advanced greatly of late, such that the genotype of Hep C is no longer a crucial factor in determining the type of treatment as current DAA used covers all genotypes. The most common genotype for Hep C in Malaysia is genotype 3 and genotype 1. There has been tremendous improvement in suistained virological response SVR and thus nearly Everyone with hep C can now be CURED! Not only are we seeing very high SVR rates; the therapies are highly tolerable and it is an all-oral therapy for almost every patient with treatment generally taking a course of just 12 weeks. Currently the DAA used for Hep C in Malaysia is Sofosbuvir/Daclatasvir±Ribavrin. She hopes that eventually it will be Ravidasvir and Sofosbuvir which is Ribavrin free, expressing support for DNDI's efforts to register Ravisdavir in Malaysia pending another round of trials which have so far been showing very promising result of SVR rate of over 97% so far.

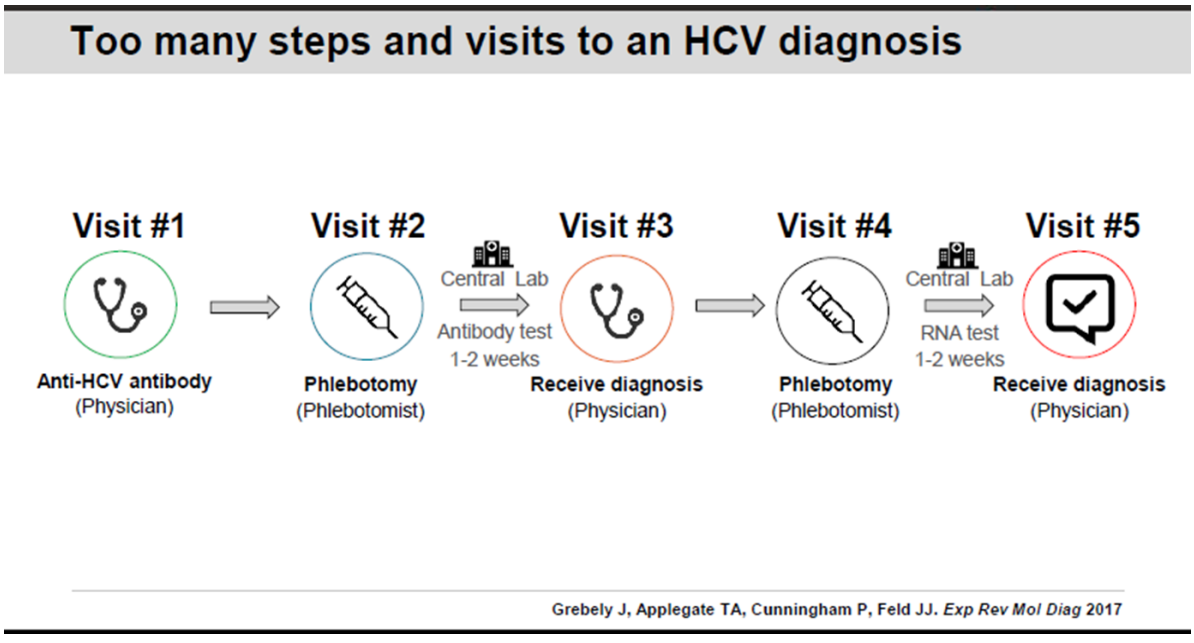
The challenges of Ribavrin (RBV):

- With SOF/DCV regimen (RBV is needed in TE NC or C unless GT1b or GT2, GT3 C, decompensated cirrhotics)
- Pill burden (addition of 5 to 6 tablets daily)
- Ribavirin induced hemolytic anemia (lethargy)
- More frequent clinic visits and more tests
- Other RBV toxicities : cough, rash, acute gout, teratogenic (need contraception)
- Cost implications (the most expensive one!)

She then spoke about the challenges faced by clinicians which included diagnosis of CHCC as well as challenges in disease management. The challenges were looked at in relation to the Hep C treatment cascade as illustrated below as well as by discussing a few case studies.



For most countries in Asia, this is the largest gap ie up to 90-95% Hep C infected are UNAWARE that they are infected there for the need is to start much earlier in the Hep C treatment cascade. Another problem is that there are too many steps in diagnosing, confirming and treating Hep C. She discussed the typical steps in diagnosing as per illustration below and mentioned that in Malaysia there is a similar problem of too many steps at this stage.

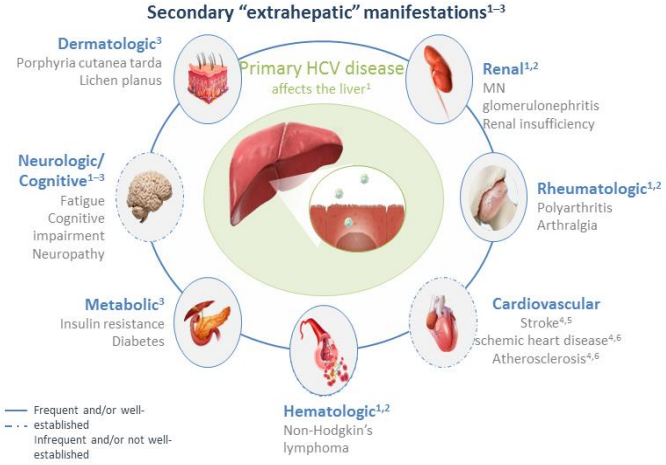


Dr Tan then explained WHO's simpler recommended approach for diagnosis as well as her own personal approach to treatment:

- Ideally HCV infection should have been confirmed (HCVRNA=detected or HCVRNA= 123,386 iu/ml or HCV Core Ag detected)
- I need to know and hence look for these:
  - Stage of liver disease (C or NC ,decompensated)

- TE or TN (decide DAA regimen)
- Co-morbid illness (referral letter or patient)
- Concommittant medications (yellow tablet?)
- Essential tests

Another thing to be aware of as a potential complication are Secondary "extrahepatic" manifestations:



She then touched on the need for removing barriers to care and highlighted that the main barrier was managing active co-morbidities. Another area to look at is potential drug-drug interactions whereby the following steps are essential:

- ✓ **Review** all medications: herbals/supplements, prescription, OTC meds, including contraceptives and PPI
- ✓ **Ask** about PRN usage of other drugs
- ✓ **Work** with clinical pharmacist when possible
- ✓ **Streamline** patients prescriptions
- ✓ Actions: change medications/dose/timing

She recommended the website hep-druginteractions.org as a key resource for this. The need for fibroscan or genotyping was then discussed. The complications of co infection with Kidney disease and HIV were then discussed briefly.

She feels that ultimately the Hep C model of care should be more community and clinc based instead of the current one which was too specialist and hospital focused. The ECHO model which combines better use of technology, shared best practices, case based learning and a web based database can be adopted to optimise this proposed new model of care. In ending Dr Tan emphasised the following take home messages:

- Elimination strategy in Malaysia requires immediate large upfront scale up in diagnosis and treatment.
- With effective and affordable DAA the challenges are in doing it.
- Challenges are unavoidable but can be resolved.
- Simplification is the key.
- Incorporate new technologies

Presentation 4: Brief on IP, compulsory Licensing and Future IP in relation to HCV medications

By Ms Sangeetha Thirumani, Advocacy Officer of Third World Network (TWN)

TWN is an NGO based in Penang and has a branch in PJ and works on improving access to affordable medicines globally. Patents cause medicines to become a luxury with exorbiotant prices and the way to overcome this is mainly via generics which calls for

- Pro public health patent law and policy
- Minimising/ Avoiding regulatory exclusivity

One problem with patents is "evergreening" under TRIPS where a new patent is imposed on drugs with existing patent to extend beyond the original patent. TRIPS is short for the "**Agreement on Trade-Related Aspects of Intellectual Property Rights"** .

- It is administered by the World Trade Organization (WTO)
- Applies to developing countries since 1995, least developed countries are exempted until January 2033.
    - Malaysia is already covered by TRIPS since 1995 as it is considered developing

Patents covers both products and processes**.** Basically patents give rights to the inventor to make money out of inventions and "discoveries". "Discoveries under IP definition are not necessarily original inventions. Besides patents, Intellectual Property (IP) "Rights" include trademarks, copyright and Geographical indication.

Before TRIPS there was freedom to decide on number of years, but TRIPS now sets minimum international standards for patents: private exclusive rights (MONOPOLY) given to patent holders for 20 years, BUT there are exceptions to that right, the right can be taken away on grounds set out in national law (including public health, public interest), and when there is anti-competitive or monopolistic behaviour by patent holders. There are flexibilities within TRIPS to enable countries to formulate their own patent regulations and standards to suit their development and national needs – flexibilities reaffirmed in 2001 Doha Ministerial Declaration on TRIPS and Public Health.

What can be patented?

- Invention - Inventive step; novel (new); capable of industrial application
- Flexibility in defining scope, governments should be guided by development priorities (encourage more R & D / innovation; public interest)
    - e.g. India does not allow patents on "new uses" of existing substances
- Loose patentability standards can result in too many secondary patents
    - Eg new combinations; new uses of existing substance; 'evergreening'
- New chemical entities or new innovative medicines are now rare, yet there are thousand of pharmaceutical patents granted each year on simple or trivial changes in existing pharmaceutical products

It is important for each country to define patents according to public interest etc. In Argentina, stricter guidelines for the examination of patentability done in 2012, number of patents granted that yr was 54, while Mexico (similar size market) number of patents in 2012 was 2500. WTO review of trade policies of Argentina discussed the Guidelines; and found it compatible with WTO TRIPS. There are flexibilities in TRIPS since its establishment, developing country and LDC Members can use thses for access to affordable medicines. The Doha Declaration adopted in 2011 as a global response to public health concerns, reaffirm the TRIPS flexibilities whereby it clarifies WTO members' rights to exercise them:

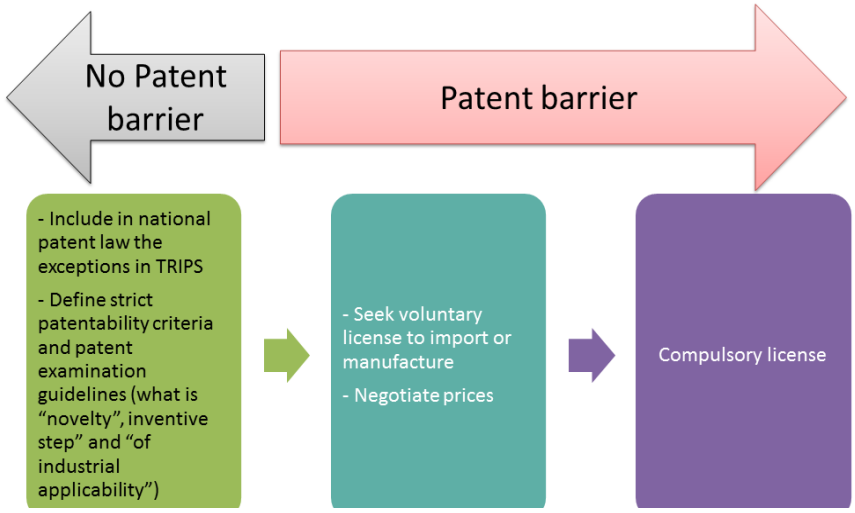
TRIPS Flexibilities Safeguarding Health

Patentability criteria	• Strict standards on criteria for "novelty", "inventive step", "industrial application" • Can exclude patentability of a known substance, second medical use, new formulation, etc. to prevent "evergreening" patents
Research exception*	• To ensure patents do not prevent scientific research
Bolar exception	• To ensure generic medicines available on the market ASAP after the patent expires
Compulsory license (CL) Public non-commercial use	• Balance insufficient use/misuse of patent or serve public interests or prevent anti-competitive behaviour (grounds for CL are set by national law – not limited under TRIPS) • "Government Use"
Pre-grant opposition/Third party observation	• To oppose before a patent is granted
Post grant opposition	• To oppose after a patent is granted, i.e. patent invalidation
Parallel import	• Source cheapest medicines manufactured under a license from patent holder

All the above "flexibilities" are incorporated in Malaysia's Patents Act except for pre-grant opposition/third party observation and strict patentability criteria

In Malaysia Patents are governed by "Malaysian Patents Act 1983" (last amendment 2007). The Ministry of Domestic Trade and Consumerism is responsible for IP and the Patents Act. Examination and granting of applications for patents and IP claims are under Intellectual Property Corporation of Malaysia (MyIPO) established in 2004 using Guidelines for Patent Examination in the IP Corporation of Malaysia (2004).

Basic Approach to Promote Access to Affordable Medicines



Compulsory license (CL) can be given if the patented invention is not being produced in Malaysia without any legitimate reason or made in Malaysia but sold at unreasonably high prices; or does not meet the public demand without any legitimate reason. TRIPS allows countries to decide on the grounds for compulsory licences to be issued (Malaysian law is too narrow). Prior negotiations with patent holder required HOWEVER, if the patent holder's behaviour is determined under Competition Law to be anti-competitive/monopolistic then a CL can be issued without prior negotiations. There is also "rights of govt" which Malaysia used in 2003 to import generic ARVs for 2 years and also in 2017 to import generic sofosbuvir (for Hep C treatment). Under "rights of govt" there is No

need for prior negotiations with patent holder. In terms of Hep C meds in Malaysia, patent status in Malaysia, we have:

- Sofosbuvir (SOF) : patented
- Daclatasvir (DCV): no patent

In 2014 Gilead's voluntary licensing agreements with Indian generic manufacturers excluded Malaysia, Thailand, China, Hong Kong, Brazil, and other middle income countries. In 2017 Gilead included Malaysia, Thailand, Ukraine and Belarus when Malaysian Cabinet decided to exercise "Government Use" compulsory licence.

Differences between CL and VL

Aspects / Types	Government use License / Compulsory license (CL)	Voluntary License (VL)
Issuer	GOV	Patent holder to generic company
Remuneration	Gov pays patent holder	Arranged agreement
Price	Low	High at times
Binding doc	TRIPS	Contractual agreement

If not for invoking the CL for sofosbuvir, we would have to wait for 11 year for the patent to expire which is not justified given the urgendy of the Hep C situation in Malaysia. DnDI (Drugs for Neglected Diseases Initiative) is working with Government of Malaysia to conduct clinical trials of a new combination of Sofosbuvir + Ravidasvir (RAV) which would be a major improvement. No matter what sofosbuvir is the backbone of DAA combinations whether SOF/Daclatasvir or SOF/Ravidasvir (future). Options now are:

- Negotiate price
- Ask voluntary license pricing
- Compulsory license

CL means the current options for Malaysia are:

(1) import of generic sofosbuvir from Egypt under the Government Use CL (for MOH and Ministry of Defence hospitals)

(2) import of generic daclatasvir (no patent so anyone can import after registering the generic product) (for public and private facilities)

(3) import of Gilead-licensed generic from voluntary licence holders in India: (Indian companies have to register their product in Malaysia) (for public and private facilities).

In the future, when ravidasvir is approved for marketing this may reduce prices (including originator patented medicines) more because of competition.

Working group: Needs vs Services

The participants were asked to discuss as groups on the issues identified which they felt needed to be addressed. In general, few issues identified among barriers to HCV testing and Hep C treatment for key population such as PWID:

- PWID might still active in drug use, potentially compromising adherence to treatment and follow up visits

- PWID less motivated to attend to health clinics for treatment follow up, as health might not be the priority of them
- PWID demotivated by the long waiting list for Hep C treatment/referrals to hospital for treatment, and multiple hospital visits to complete the treatment process
- Stigma and misconceptions on the side effects of Hep C treatment among the PWID community due to previous treatment regimes

Breakout group discussion : Healthcare needs for the Key populations: Recommendations & Approach

An overview was given of the WHO guideline for KPs/package of services which are the standards that we in Malaysia should aspire to (refer to appendix 7). With this in mind and to sum up the input received throughout the day, the discussion proceeded to what can be done, what can't be done with the view to creating a mini action plan/recommendations thereof.

In order to do this the participants were made to discuss in break-out groups, participants were about the challenges/gaps in detail, and propose some action plan to close the gaps that exists in different phases of Hep C patient flow which was to be broken into the following phases for ease of discussion:

- Pre-testing phase
- Testing/diagnostic phase
- Linkages to care/clinic phase
- Treatment follow-up phase

Refer to **appendix 2** for the output from this discussion which is a draft proposed action plan.

Appendix 1: Proposed Workshop Agenda

Date & Time	Topic
8.00 am-9.00 am	Registration
9.00 am- 9.15 am	Welcome Speech
9.15 am-9.45 am	**HIV and Key Populations: Who are they in the community?** - Why KPs relevant to our work - IBBS - Who are KPs
9.45 am-10.00 am	**Initiatives and programme available addressing needs of Key Populations** - All the programme available via MAC - Initiatives of MOH (such as KK Model, STI Client friendly clinic, CBT etc.)
10.00 am- 10.30 am	Coffee Break
10.30 am-11.15 am	Treatment & Challenges Community Perspective
11.15 am-12.00 pm	HCV Treatment and Challenges Clinicians Perspective
12.00 am-12.45 pm	Brief on IP , compulsory Licensing and Future IP in relation to HCV medications
01.00 pm- 02.00 pm	Lunch Break
2.00 pm- 3.15pm	**Working group: Needs vs Services** - 30 mins discussion in group - 45 mins presentations + discussion
3.15 pm- 5.00 pm	**Breakout group discussion:** **Healthcare needs for the Key populations: Recommendations & Approach** - WHO guideline for KPs/package of services - Discussion on the floor on what can be done, what can't be done + Mini action plan/recommendations from the group

Appendix 2: Proposed action plan

Disclaimer: *Please note the following issues identified and proposed action plan were based on the group discussions among the participants of the workshop.*

Pre-Testing Phase

No.	Issues/gaps	Action Plan	Parties involved
1	Understanding the situation locally: Who are the KPs affected the most by Hep C infection?	To conduct small scale/state level research or data analysis to identify who are the at risk populations in the state	KKM JKN PKD NGO
2	Linking Hep C infected PWID to care	To ensure availability of rapid test kits (RTK) at clinics & outreach sites of the states	JKN
	1) Screening	To train outreach workers on HCV screening using the rapid test kits	
	2) Promotion of the screening and advocacy	To promote the need of HCV screening & advocating for support on it - Health promotion on HCV screening: Community outreach workers using tablet/smart phone equipped with education package to educate HCV infected PWID on Hep C and its treatment (eg Pictures showing Hep C complications and flow of Hep C treatment)	NGO Note MAC community friendly booklet and online tool kit will serve this purpose
		To organize campaign on Hep C to sensitize and improve awareness among the public and healthcare workers on Hep C screening and treatment	PKD, JKN, MGO
3	Hep C treatment among the non-PWID/MMT patients with Hep C	To explore ways to approach non-PWID or MMT patients with Hep C infection - Social apps? - Radio blast campaign? - Incentives to support patients for follow-up?	JKN, NGO
4	Ownership issues by employers most affected by Hep C (eg PWID fishermen, PWID in FELDA)	To consider including Hep C screening and Hep C treatment promotion through KOSPEN Plus Model's screening component (Komuniti Sihat Perkasa Negara, KOSPEN) - Promote healthy and productive workforce via good working	JKN

		environment - Involving the employer to take on ownership to ensure productive and healthy workforce by including HCV screening in the KOSPEN Plus program	
5	Lack of awareness and interest from other agencies in Hep C	Realignment of agencies area of interest - Dialog sessions with different agencies relevant to Hep C infected populations - Common Memorandum of Understanding signed between agencies	JKN

Testing/Diagnostic Phase

No.	Issues	Action Plan	Parties involved
Existing HCV testing sites: HIV Clinic, Methadone Clinic, MSA/STI Clinic, Voluntary Testing site, Community Based Testing (?), Outreach Programme			
1	Low number of Hep C cases notified - Unclear disease burden, hence lack of resources - Partially due to unclear guidelines in Hep C screening and management	To consider revision of Hep C management guideline / facilitate & simplify the understanding of Hep C testing algorithm & treatment guideline	MOH
2	Capacity gaps of healthcare workers in primary healthcare setting (Klinik Kesihatan) managing Hep C patients	To train MO, FMS, SN, MA regarding Hep C treatment available (to disseminate the right info) via various channels: - Online course - Clinic attachment - Rotation	

		- Knowledge sharing session (to understand the guideline)	
3	Non-specific barriers for HCV screening implementation	To organize group support to HCV patients/PWID (peer support) - To spread good "rumours" that Hep C is curable, and ongoing revision on allocation of funds to treat HCV patients	
		To equip the lab with diagnostic test - Infrastructure at referral centres for confirmatory test need to be ready to receive referrals from health clinics (Klinik Kesihatan)	
		To create awareness to healthcare workers on HCV screening and Hep C treatment, & contact tracing awareness	

Linkages to care/clinic Phase

No.	Issues	Action Plan	Parties involved
1	Miscommunication issues between healthcare workers & HCV patients, especially PWID patients	To organize capacity building activities/trainings for healthcare workers to address the following issues: - Discrimination, Stigma, breach of confidentiality - Less caring towards Hep C patients - Inappropriate counselling approach	
2	Gaps in healthcare workers' capacity in managing Hep C patients	To set up dedicated team for Hep C management to look into the following – Hep C patients defaulter tracing - No personalize care for Hep C patients - High turn-over of staffs managing Hep C patients in Klinik Kesihatan	

3	Facility in the clinic need further improvement	To upgrade facility in selected clinics to handle Hep C patients load - Depending on the needs of the populations - Gaps in documentation system in clinic	
4	No dedicated team for Hep C patients (home visit)	To form a dedicated team to trace Hep C defaulted patients	
5	Limited choice of clinic near the house	To expand Hep C treatment to klinik kesihatan – patients should be given the options to choose clinics of their choice	

Treatment Follow-up Phase

No.	Issues	Action Plan	Parties involved
1	Going through side effects of treatment by Hep C patients	To provide capacity building to healthcare workers in communicating with Hep C patients on Hep C treatment: - Proper Hep C counselling - Risks vs Benefits of starting treatment	
2	Frequent follow-up for Hep C patients even before initiation of treatment (more challenging to PWID Hep C patients)	To set up dedicated team / having person-in-charge to manage Hep C patients appointments and follow-up To empower FMS for Hep C treatment initiation	
3	Hep C patients still active on drug use	To emphasize on counselling PWID patients on Hep C infections and harm reduction - To avoid reinfection of Hep C if patient still active on drug	
4	Awareness on the importance of compliance	To improve efforts in health promotion among the Hep C patients and	

	to Hep C treatment is still low	provide peer support to Hep C patients (especially PWID patients)	
5	Distance from Hep C patients' home to clinic a barrier for PWID patients to attend clinic	To have case worker assisting Hep C patients along the process of getting treatment of Hep C	
6	Waiting list for treatment initiation is too long (after HCV screening and diagnosis)		
7	Stigma exist among PWID patients attending clinic		

Prepared by: Chung Han Yang, December 2018

List of additional appendixes:

1. Appendix 3: Slides for Presentation 1
2. Appendix 4: Slides for Presentation 2
3. Appendix 5: Slides for Presentation 3
4. Appendix 6: Slides for Presentation 4
5. Appendix 7: Slides for action plan discussion